Dickinson

WELLNESS CENTER

Health Services
PO BOX 1776, Carlisle, PA 17013 717-245-1663 phone 717-245-1938 fax

ALLERGY INJECTIONS
Student Instructions and Responsibilities

The Wellness Center will administer allergy injections on the written order of your allergist who has provided you with the appropriate serum.

1. The student is responsible for taking the Physician Instructions and Allergy Immunotherapy Checklist to their physician and assuring their vials and instructions are in compliance with the Wellness Center policy. We will not administer injections from inadequately labeled vials or if physician's instructions are missing or incomplete.

2. The student is responsible for having current instructions, schedules, and serums at the Wellness Center. They are also responsible for adhering to their schedule and obtaining refill serum as needed.

3. The student is responsible for making their appointments for allergy injections at the Wellness Center. Allergy forms will be reviewed by the medical provider on the first visit. The student will be given the Allergy Immunotherapy Instruction Sheet and the Consent for Allergy Immunotherapy on their first visit. The student is responsible for reading and understanding the instruction sheet. By signing the consent, the student agrees to the policies of the Wellness Center.

4. The student is responsible for arranging their own injections while they are away from campus.

5. The student is responsible for checking out their serum and a copy of their record during the holiday periods and at the end of the academic year.

6. There may be charges associated with injections. While we do not participate in or bill any insurance plans, we do provide receipts to submit for reimbursement.

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ALLERGY INJECTIONS
Physician Instructions

The Dickinson College Wellness Center provides the care that our students need in the safest way possible. Your assistance in this is greatly appreciated.

Our allergy clinic serves many patients referred by various allergy specialists. Each allergy specialist has unique forms that they use in their office. As you can imagine, navigating different forms is very challenging and has significant potential for error. Therefore, to maximize the safety of our students, each form must contain:

- Patient demographic data
- Physician office information
- Record of the last injection given
- The schedule for future injections
- The way to identify vials and their contents
- Instructions for pre-injection (if any), missed/late injections, and reactions

Alternatively, you may use the Allergen Immunotherapy Order form that our clinic provides.

We also require the following to maintain student safety:

- Initial injection(s) must be performed at the allergist's office.
- We will not mix or dilute any extracts; this must be done by the prescribing allergist. We will store extracts in the allergy clinic.
- Vials must be clearly labeled with:
    - Patient's name
    - Name of the antigen(s)
    - Dilution
    - Expiration date
- The Dickinson College Wellness Center's Allergy Immunotherapy Checklist MUST be completed yearly (on the next page) and be provided to our allergy clinic prior to a student receiving injections.

Failure to comply with any requirement could delay and potentially prevent utilization of our services

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Attn: Jennifer Braund, CRNP
PO BOX 1776, Carlisle, PA 17013 717-245-1663 phone 717-245-1938 fax

ALLERGY IMMUNOTHERAPY CHECK LIST

Student _____ D.O.B._____

TO BE COMPLETED AND SIGNED BY THE PRESCRIBING PHYSICIAN:

Our facility has a part-time physician for four hours/week and is staffed full-time with advanced practice providers (CRNPs and PAs) who are CPR certified. Emergency equipment is present, and protocols are posted. The local hospital emergency department is two miles from campus. Given this information, my patient may receive injections at the Dickinson College Wellness Center.

1. Does the patient have any chronic or severe illness which might affect general health or desensitization schedule?
   ☐ yes ☐ no Specify: _____
2. Do you alternate arms with each injection?
   ☐ yes ☐ no
3. How long must your patient wait to exercise after receiving allergy injections?
   _____hours
4. Is your patient permitted to have their injections > once a week?
   ☐ yes, minimum days between injections _____
   ☐ no
5. Has the patient had previous severe local or systemic reactions to the antigen(s)?
   ☐ yes ☐ no
   If yes, please indicate type and treatment: _____
6. May your patient receive a flu vaccine during the week of allergy injection(s)?
   ☐ yes ☐ no
   ☐ must wait _____ days between the two

Physician's Signature: _____Date: _____

Physician Name: _____ Allergy Contact: _____

Phone: _____ Fax: _____

Address: _____

City State Zip: _____

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Allergen Immunotherapy Order Form

For your patient's safety and to facilitate the transfer of allergy treatment to our clinic, this form must be completed to provide standardization and prevent errors. Failure to complete this form will delay or prevent the patient from utilizing our services. Form can be delivered by the patient, mailed, or faxed (see address and fax above).

Patient Name: Date of Birth:
Physician: Office Phone: Secure Fax:
Office Address:

PRE-INJECTION CHECKLIST:

- ☐☐ Is peak flow required prior to injection? NO YES: **If yes**, peak flow must be ≥ _____L/min to give injection.
- ☐☐ Is student required to have taken an antihistamine prior to injection? NO YES

INJECTION SCHEDULE:

Begin with ___ (dilution) at ___ml (dose) and increase according to the schedule below.

Dilution					
Vial Cap Color					
Antigen Name					
Expiration Date(s)	____/____/	____/____/____	____/____/____	____/____/	____/____/
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	ml	ml	ml	ml	ml
	Go to next Dilution	*Go to next Dilution*	*Go to next Dilution*	*Go to next Dilution*	ml

MANAGEMENT OF MISSED INJECTIONS: (According to number of days from ***LAST*** injection)

During Build-Up Phase	***After Reaching Maintenance***
▪ ___ to ___ days – continue as scheduled	▪ ___ to ___ days – give same maintenance dose
▪ ___ to ___ days – repeat previous dose	▪ ___ to ___ weeks – reduce previous dose by _____ (ml)
▪ ___ to ___ days – reduce previous dose by _____ (ml)	▪ ___ to ___ weeks – reduce previous dose by _____ (ml)
▪ ___ to ___ days – reduce previous dose by _____ (ml)	▪ Over ____ weeks – contact office for instructions
▪ Over _____ days – contact office for instructions	

REACTIONS:

At next visit: Repeat dose if swelling is > mm and < mm.
Reduce by one dose increment if swelling is > mm.

Physician Signature: _____ Date: